MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Wol-Med Clinic 2436 I-35 E. South, Ste. 336 Denton, TX 76205	MDR Tracking No.: M4-03-6489-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Pacific Employers Insurance Co.	Date of Injury: Employer's Name: Insurance Carrier's No.: C290C0867548

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
09/12/02	12/27/02	97039, E1399, 99213, 99080-73, 97035	$157.50	$66.10

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 06/02/03 states in part, "…Date of service 12-11-02 was denied with Payment Exception Code "F-Fee Guideline MAR reduction". This is an incorrect PEC. Code 97039 has no MAR. We feel the carrier failed to comply with Rule 133.304, Medical Payments and Denials… The other dates of service were denied with PEC "C-negotiated contract price". We are not now and have never been on any WC PPO's. We feel the carrier failed to comply with Rule 133.1…"

PART IV: RESPONDENT'S POSITION SUMMARY

The respondent did not submit a position summary.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- **CPT Code 97039-FT** (2 units) for date of service 12/11/03 denied as "F – Reduction according to Medical Fee Guideline." This CPT Code does not have MAR. Per Rule 133.1(a)(8) the requestor has not submitted convincing evidence, i.e., redacted EOBs or other methodology, to support the amount billed is their fair and reasonable amount billed; therefore, additional reimbursement is not recommended.
- **CPT Code 99213** for dates of service 09/10/02, 09/24/02, 11/30/02 and 12/23/02 denied as "C – Negotiated Contract." Per Rule 413.011 the requestor has submitted convincing evidence that they are not under contract with Focus/Evolutions HEA; therefore, additional reimbursement in the amount of $38.40 ($9.60 x 4) is recommended.
- **CPT Code 99080-73** for date of service 09/10/02 denied as "C – Negotiated Contract." Per Rule 413.011 the requestor has submitted convincing evidence that they are not under contract with Focus/Evolutions HEA; therefore, additional reimbursement in the amount of $38.40 ($9.60 x 4) is recommended.
- **HCPCS Code E-1399** for date of service 09/12/02 denied as "C – Negotiated Contract." Per Rule 413.011 the requestor has submitted convincing evidence that they are not under contract with Focus/Evolutions HEA; however, the 1996 Medical Fee Guideline, DME Ground Rule (X)(C) the maximum allowable amount for TENS supplies is $85.00, therefore, additional reimbursement in the amount of $18.05 is recommended.
- **CPT Code 97035** for date of service 12/27/02 denied as "C – Negotiated Contract." Per Rule 413.011 the requestor has submitted convincing evidence that they are not under contract with Focus/Evolutions HEA; therefore, additional reimbursement in the amount of $4.40 is recommended.
- **CPT Code 97039-FT** for date of service 12/27/02 denied as "C– Negotiated Contract." Per Rule 413.011 the requestor has submitted convincing evidence that they are not under contract with Focus/Evolutions HEA; however, this code does not have a MAR, per Rule 133.1(a)(8) the requestor has not submitted convincing evidence, i.e., redacted EOBs or other methodology, to support the amount billed is their fair and reasonable amount billed; therefore, additional reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
09/10/02 -							
12/23/2002	99213	$38.40	$38.40				
9/10/2002	99080-73	$5.25	$5.25				
9/12/2002	E-1399	$36.05	$18.05				
12/11/02 -							
12/27/2002	97039-FT	$73.40	$0.00				
12/27/2002	97035	$4.40	$4.40				
						Total Left Column:	$157.50
						Total Amount Due:	$66.10

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $66.10. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster	01-13-05
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____